SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: IND APPS 2010-Life	SERFF Tr Num: SEFL-126646674	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 46330
Sub-TOI: L08.000 Life - Other	Co Tr Num: IND APP 2010-LIFE	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Kristi Hendrickson	Disposition Date: 08/03/2010
	Date Submitted: 07/27/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: IND APPS 2010-Life
Project Number: IND APPS 2010-Life
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/03/2010

Deemer Date:
Submitted By: Kristi Hendrickson
Filing Description:

Status of Filing in Domicile: Authorized
Date Approved in Domicile:
Domicile Status Comments: Approved
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/03/2010
Created By: Kristi Hendrickson
Corresponding Filing Tracking Number:

Form No. Form Title
47-350-05051 (R05-10) Application for Insurance
47-351-05051 (R05-10) Trust Information/Additional Beneficiary
47-352-05051 (R05-10) General Section
47-354-05051 (R05-10) Physician Information and Agreement
47-355-05051 (R05-10) Life Product Section
47-357-05051 (R05-10) Universal Life Product Section
47-362-05051 (R05-10) Field Underwriter’s Statement
75-315-02201 Guaranteed Insurability Insurance Application

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

75-802-05055 Temporary Conditional Insurance Agreement
75-819-05055 Tobacco Use Questionnaire

Form Replacement
Form No. Replaced Form No. Approval Date Filing No.
47-350-05051 (R05-10) 47-350-05051 (R02-08) 04/10/2008 38537
47-351-05051 (R05-10) 47-351-05051 12/07/2006 SEFL-125052416
47-352-05051 (R05-10) 47-352-05051 (R02-08) 04/10/2008 38537
47-354-05051 (R05-10) 47-354-05051 (R02-08) 04/10/2008 38537
47-355-05051 (R05-10) 47-355-05051 (R09-08) 10/20/2008 40487
47-357-05051 (R05-10) 47-357-05051 12/07/2006 SEFL-125052416
47-362-05051 (R05-10) 47-362-05051 (R02-08) 04/07/2008 38537
75-802-05055 LU-CR (06/05) 08/25/2005 unknown
75-819-05055 A-DI/A 34 08/02/2001 unknown

Form Utilization and Main Changes
47-350-05051 (R05-10), Application for Insurance – This page is utilized to record the personal information of the proposed insured, policyowner, beneficiaries, and proposed joint-insured, if any. This page also records the premium payment mode and payor information if the payor is different than the policyowner or proposed insured. The main changes are asking for the amount of tobacco used per day and the Premium Payment section.

47-351-05051 (R05-10), Trust Information/Additional Beneficiary – This page is to be utilized if the owner and/or beneficiary is a trust or if additional room is needed to list beneficiaries for the policy. The main change is in the layout of the form.

47-352-05051 (R05-10), General Section – This page is utilized to record the answers to the general questions. The main changes are in the replacement questions (9a & 9b) and the addition of question 10.

47-354-05051 (R05-10), Physician Information and Agreement – This page is utilized to record the primary physician's information and all necessary signatures. The main change is in the Physician Information section.

47-355-05051 (R05-10), Life Product Section – This page is utilized when applying for a term or whole life insurance sold by our licensed brokers and agents. The main changes are the addition of asking the purpose of the insurance at the top of page 1 and asking about the other insured's permanent resident status and driver's license information at the bottom of page 2.

47-357-05051 (R05-10), Universal Life Product Section – This page is utilized when applying for a universal life insurance product sold by our licensed brokers and agents. The main changes are the addition of asking the purpose of

the insurance at the top of the page and asking about the other insured's permanent resident status and driver's license information at the bottom of the page.

47-362-05051 (R05-10), Field Underwriter's Statement – This page provides additional underwriting information to the Company from the licensed broker/agent. The main changes are questions 3 – 8 and asking for the other insured's proposed underwriting class for term, whole and universal life.

75-315-02201, Guaranteed Insurability Insurance Application – This page is utilized when applying for additional disability income insurance as provided by a guaranteed insurability rider. The main difference to this form is to make it look and appear like the other Assurity forms.

75-802-05055, Temporary Conditional Insurance Agreement – This form is used when a premium payment is included with an application for life or reversionary annuity coverage. The main change to this form is making it specific to lines of business and adding the health questions.

75-819-05055, Tobacco Use Questionnaire – This page is utilized when applying for non-tobacco rates on an in-force policy that was issued at tobacco rates. The main difference to this form is to make it look and appear like the other Assurity forms.

Marketing
These forms will be used by licensed agents and brokers who sell Assurity products.

Company and Contact

Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist
1526 K Street
Lincoln, NE 68508

policyfiling@assurity.com
402-437-3452 [Phone]
402-437-3802 [FAX]

Filing Company Information

Assurity Life Insurance Company
1526 K Street
P.O. Box 82533
Lincoln, NE 68501-2533
(800) 276-7619 ext. [Phone]

CoCode: 71439
Group Code: -99
Group Name:
FEIN Number: 38-1843471

State of Domicile: Nebraska
Company Type: Life/Health
State ID Number:

Filing Fees

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

Fee Required?	Yes
Fee Amount:	$450.00
Retaliatory?	No
Fee Explanation:	50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	$450.00	07/27/2010	38307691

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/03/2010	08/03/2010

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

Disposition

Disposition Date: 08/03/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Application for Insurance		Yes
Form	Trust Information/Additional Beneficiary		Yes
Form	General Section		Yes
Form	Physician Information and Agreement		Yes
Form	Life Product Section		Yes
Form	Universal Life product Section		Yes
Form	Field Underwriter's Statement		Yes
Form	Temporary Conditional Insurance Agreement		Yes
Form	Tobacco Use Questionnaire		Yes

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

Form Schedule

Lead Form Number: 47-350-05051 (R05-10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	47-350-05051 (R05-10)	Application/ Enrollment Form	Application for Insurance	Revised	Replaced Form #: 47-350-05051 (R02-08) Previous Filing #: 38537	55.600	47-350-05051 _R05-10_.pdf
	47-351-05051 (R05-10)	Application/ Enrollment Form	Trust Information/Additional Beneficiary	Revised	Replaced Form #: 47-351-05051 Previous Filing #: SEFL-125052416	64.400	47-351-05051 _R05-10_.pdf
	47-352-05051 (R05-10)	Application/ Enrollment Form	General Section	Revised	Replaced Form #: 47-352-05051 (R02-08) Previous Filing #: 38537	50.000	47-352-05051 _R05-10_.pdf
	47-354-05051 (R05-10)	Application/ Enrollment Form	Physician Information and Agreement	Revised	Replaced Form #: 47-354-05051 (R02-08) Previous Filing #: 38537	50.300	47-354-05051 _R05-10_.pdf
	47-355-05051 (R05-10)	Application/ Enrollment Form	Life Product Section	Revised	Replaced Form #: 47-355-05051 (R09-08) Previous Filing #: 40487	53.000	47-355-05051 _R05-10_.pdf
	47-357-05051 (R05-10)	Application/ Enrollment Form	Universal Life product Section	Revised	Replaced Form #: 47-357-05051 Previous Filing #: SEFL-125052416	54.000	47-357-05051 _R05-10_.pdf
	47-362-	Application/	Field Underwriter's	Revised	Replaced Form #:	57.300	47-362-05051

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

05051 (R05-10)	Enrollment Form	Statement		47-362-05051 (R02-08) Previous Filing #: 38537		_R05-10_.pdf
75-802-05055	Application/ Enrollment Form	Temporary Conditional Insurance Agreement	Initial		50.800	75-802-05055 05-10.pdf
75-819-05055	Application/ Enrollment Form	Tobacco Use Questionnaire	Initial		65.900	75-819-05055.pdf

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Application for INSURANCE

PLEASE PRINT IN BLUE OR BLACK INK

1. PROPOSED INSURED

Legal Name (*First, Middle, Last*) | Date of Birth (*MM/DD/YYYY*) / /

Social Security No. | ☐ Male ☐ Female | E-mail | Age

Home Address (*Street Address, City, State, ZIP+4*)

Personal Phone No. ( ) | Birth State/Country | Height ft. in. | Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type: amount per day: last date of use (*MM/DD/YYYY*) / /

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If the Proposed Insured has permanent resident status, please list permanent resident *(green card)* number.

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number.

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment (*Years Months*) /

Primary Employer | Employer's Address (*Street Address, City, State, ZIP+4*)

Full-time Employment (*Occupation, Duties*) | Part-time Employment (*Occupation, Duties*)

Gross monthly income $ | If self-employed, net monthly income $

2. POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

If Ownership is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Legal Name (*First, Middle, Last*) | Date of Birth (*MM/DD/YYYY*) / /

Social Security No. | Relationship to Insured | Birth State/Country

Home Address (*Street Address, City, State, ZIP+4*) | E-mail

Contingent Owner's Name (*First, Middle, Last*) | Contingent Owner's Relationship to Insured

3. BENEFICIARIES *(Do not complete if applying for Reversionary Annuity coverage)*

If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary form.

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	

4. PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type

☐ Direct Billing ☐ Automatic Credit Card
☐ List Billing *(employer)* ☐ Automatic Bank Withdrawal

Frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Monthly *(not available with Direct Billing)*

Payor Name (*First, Middle, Last*) | Billing Address (*Street Address, City, State, ZIP+4*)

Secondary Payor Info. (*First, Middle, Last*) | Billing Address (*Street Address, City, State, ZIP+4*)

TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust *(or if additional room is needed to list beneficiaries of Policy)*:

1. POLICYOWNER

Name of Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Address of Trustee(s) *Street Address* *City* *State* *ZIP+4*

2. BENEFICIARIES

☐ Testamentary Trust *(Will)* Share % _____

☐ Living Trust *(Please complete information below.)* Share % _____

Name of Living Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Street Address *City* *State* *ZIP+4*

Address of Trustee(s)

3. ADDITIONAL BENEFICIARIES *(Do not complete if applying for Reversionary Annuity)*

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Contingent Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? ☐ Yes ☐ No

2. During the past **5 years** or within the next **12 months**:

   a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating flying as a pilot, crew member or student? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? ☐ Yes ☐ No

   If YES, check all that apply:
   ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding
   ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports
   ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

3. During the next **12 months**, does any Proposed Insured contemplate residence or travel outside of the United States? ☐ Yes ☐ No

   If YES, please explain _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, amount of weight change and reason for change:

   _____

5. During the past **5 years**, has any Proposed Insured:

   a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? ☐ Yes ☐ No

   If YES, please explain _____

   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No

   If YES, please explain _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain _____

7. During the past **5 years**, has any Proposed Insured:

   a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence *(DUI/DWI)*, or had more than 3 moving violations? ☐ Yes ☐ No

   If YES, please explain _____

   b. Been convicted of a felony? ☐ Yes ☐ No

   If YES, please explain _____

8. Is any Proposed Insured currently on probation? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

   _____

9. a. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

   If YES, provide details below. If any Proposed Insured is applying for life coverage, complete and return the appropriate State Replacement Form.

   b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

   If Yes and applying for health coverage, please complete and return the appropriate State Replacement Form.

Insured's Name	Company Name	Policy No.	Individual (I) Group (G)	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only	
						Coordinates w/ Soc. Sec.?	Employer Paid?
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No

10. **If the Proposed Insured is a juvenile,** please list the total amount of life insurance in force and pending on **all** family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
$	$	$	$	$	$	$

PHYSICIAN INFORMATION

Please list the last physician seen:

Name _____ Date last consulted ____/____/____
MM/DD/YYYY

Address _____
Street Address *Suite*

_____
City *State* *ZIP+4*

Phone No. (____) _____ Fax No. (____) _____

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

_____

AGREEMENT

I *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the policy if attached thereto.

I *(We)* agree that:

a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.

b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.

c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Substitute Form W-9 information *(Request for Taxpayer Identification Number and Certification)*: I, the Owner *(or each Joint Owner)*, certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person *(including a U.S. resident alien)*. The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ on ____/____/____
City *State* *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured *Signature of Additional Proposed Insured*

_____ _____
Signature of Parent/Guardian of Minor Child *Signature of Additional Proposed Insured*

_____ _____
Signature of Owner(s) (If other than Proposed Insured) *Signature of Beneficiary (If applying for Reversionary Annuity)*

_____ _____
Signature of Licensed Agent *Print Agent Name and Agent No.*

LIFE PRODUCT SECTION

What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____

TERM LIFE INSURANCE

Face Amount $ _____ Number of years for policy: ☐ 10-Year ☐ 15-Year ☐ 20-Year ☐ 30-Year

ADDITIONAL BENEFITS AVAILABLE ON TERM LIFE—Check benefit(s) desired and indicate amount requested where applicable.

☐ Disability Waiver of Premium Benefit Rider

☐ Monthly Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Critical Illness Benefit Rider for Primary Insured $ _____

☐ Children's Term Insurance Rider *(complete next page)* _____ units

☐ Other Insured Term Insurance Benefit Rider *(complete next page)* $ _____

☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Critical Illness Benefit Rider- Other Insured *(complete next page)* $ _____

☐ Return of Premium Benefit Rider

WHOLE LIFE INSURANCE

Face Amount $ _____

If cash value is available, should the Automatic Premium Loan *(APL)* provision be made effective? *(If no option chosen, APL will apply.)* ☐ Yes ☐ No

Nonforfeiture Option: *(If no option chosen, ETI will apply)* ☐ Extended Term Insurance *(ETI)* ☐ Reduce Paid-Up Insurance *(RPU)*

Dividend Option: *(If no option chosen, PUA will apply)* ☐ Paid-up Additions *(PUA)* ☐ Accumulate at Interest ☐ Reduce Premium/PUA ☐ Reduce Premium/Cash ☐ Paid in Cash

ADDITIONAL BENEFITS AVAILABLE ON WHOLE LIFE—Check benefit(s) desired and indicate amount requested where applicable.

☐ Disability Waiver of Premium Benefit Rider

☐ Monthly Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Critical Illness Benefit Rider for Primary Insured $ _____

☐ Children's Term Insurance Rider *(complete next page)* _____ units

☐ Protected Insurability Benefit Rider $ _____

☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Critical Illness Benefit Rider- Other Insured *(complete next page)* $ _____

☐ Accidental Death Benefit Rider $ _____

☐ Level Term Insurance Benefit Rider for Primary Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ _____

☐ Level Term Insurance Benefit Rider — Other Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ _____

☐ Payor Benefit Rider *(Complete Health Section for Payor)* Payor Name _____ DOB ___/___/___ ☐ M ☐ F

☐ Paid-Up Additions Rider *(VER)* ☐ Periodic Premiums $ _____ ☐ Single Premium $ _____

SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount $ _____

Dividend Option: *(If no option chosen, PUA will apply)* ☐ Paid-Up Additions *(PUA)* ☐ Paid in Cash

OTHER INSURED AND CHILD RIDER INFORMATION—If additional space is needed, attach a separate sheet of paper.

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to Proposed Insured				
Employer				
Occupation/Duties				
Gross monthly income	$			
If self-employed, net monthly income	$			

Has the Other Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No
(Not applicable to Child Riders.)

If YES, please list type: amount per day: last date of use *(MM/DD/YYYY)* / /

Is the Other Insured a United States citizen, or does the Other Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If the Other Insured has permanent resident status, please list permanent resident *(green card)* number.

Does the Other Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number .

UNIVERSAL LIFE PRODUCT SECTION

What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____

Plan of Insurance *(check one)*: ☐ Select Universal Life ☐ Premier Universal Life

Face Amount $ _____ Special Policy Date *(If desired)* _____

Planned periodic premium annualized $ _____ Amount of Insurance is Face Amount unless shown differently here: ☐ Face + Accumulated Value

ADDITIONAL BENEFITS

Check benefit(s) desired and indicate amount requested.

☐ Disability Waiver		☐ 10-year Additional Insured/Spouse Rider	$
☐ Face Amount Increase Rider	$	☐ 20-year Additional Insured/Spouse Rider	$
☐ ADB *(Accidental Death Benefit)*	$	☐ Children's Term Rider	$
☐ 10-year Term Rider	$	☐ Other *(Please specify)* _____	$
☐ 20-year Term Rider	$	☐ Other *(Please specify)* _____	$

ADDITIONAL INSURED AND CHILD RIDER INFORMATION—If additional space is needed, attach a separate sheet of paper.

Information	Additional Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Face Amount/Units *(Child Rider)*	$ /	$ /	$ /	$ /
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to Proposed Insured				
Employer				
Occupation/Duties				
Gross monthly income	$			
If self-employed, net monthly income	$			

Has the Additional Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type: amount per day: last date of use *(MM/DD/YYYY)* / /

Is the Additional Insured a United States citizen, or does the Other Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If the Additional Insured has permanent resident status, please list permanent resident *(green card)* number.

Does the Additional Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number.

FIELD UNDERWRITER'S STATEMENT

1. a. What amount was collected with this application? $ _____

   b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No

   c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No

2. a. Did you personally see all Proposed Insured(s) on the date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ Not at all

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. ☐ Yes ☐ No

   _____

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No

   Agent is responsible for scheduling exam items.

   NOTE: ANY PREFERRED PLANS REQURE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.

   ☐ Paramedical examination ☐ Blood Sample ☐ Urine Sample ☐ Electrocardiogram *(EKG)* ☐ Treadmill EKG ☐ Medical exam by physician

4. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

6. Was sales material used in soliciting this application? ☐ Yes ☐ No

7. Was the sales material left with the applicant? ☐ Yes ☐ No

8. Was the sales material approved by Assurity Life Insurance Company? ☐ Yes ☐ No

9. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ % Agent No. _____ %

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.

☐ Add to existing bank withdrawal—indicate other applicant and/or policy numbers _____

☐ Set up NEW credit card payment—submit signed authorization with the application.

LIST BILL

☐ Set up NEW list bill— submit signed authorization with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

FOR TERM LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:

$350,000 and under: ☐ Select + NT ☐ Select NT ☐ Standard NT ☐ Select + T ☐ Select T ☐ Standard T

$350,001 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Standard NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR WHOLE LIFE APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)***

The premiums for this application were quoted on the following underwriting classification:

$99,999 and under: ☐ Select NT ☐ Standard T

$100,000 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR UNIVERSAL LIFE APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)***

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Additional Insured's underwriting classification _____

FOR REVERSIONARY ANNUITY APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)***

The premiums for this application were quoted on the following underwriting classification: ☐ Preferred NT ☐ Standard NT ☐ Tobacco

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____	/ /	( ) / ( )
Signature of Soliciting Agent	*Date (MM/DD/YYYY)*	*Business Phone No. and Fax No.*
_____	_____	_____
Soliciting Agent's Printed Name	*Agent No.*	*Agent's E-mail*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

Proposed Insured No. 1 _____ Date Application Signed ___/___/___

Proposed Insured No. 2 _____ Date Application Signed ___/___/___

In consideration of the premium received with the life insurance application listed above *(Application)*, Assurity Life Insurance Company *(Assurity)* will provide temporary life insurance coverage subject to the terms and conditions contained in this Agreement. Make all checks payable to Assurity. Do not make checks payable to the agent. Do not leave the check payee blank.

NOTE: On questions 1-2 answer according to what product(s) is being applied for.
If questions 3 a-d are answered YES or are left BLANK, there will be NO CONDITIONAL COVERAGE
The agent is not authorized to accept a premium under these circumstances.

1. a. **LIFE**—Is any Proposed Insured younger than 15 days old or older than 75 years old? ☐ Yes ☐ No
   b. **LIFE**—Does the Application, combined with the total amount of insurance in force on any Proposed Insured's life with Assurity exceed $500,000 for ages 15 days through 69 years? ***or*** $250,000 for ages 70 through 75? ☐ Yes ☐ No
2. **Reversionary Annuity**—Does the in-force and applied for life coverage, including the present value of any reversionary annuity policy exceed $100,000? ☐ Yes ☐ No
3. Has any Proposed Insured:
   a. **Ever** had a heart, lung, liver or kidney disease or disorder; diabetes; stroke; paralysis or cancer? ☐ Yes ☐ No
   b. **Ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)* or AIDS-related complex *(ARC)*? ☐ Yes ☐ No
   c. During the past **5 years** been treated, counseled or advised to seek treatment for drug/alcohol abuse? ☐ Yes ☐ No
   d. During the past **90 days** been admitted, or advised by a medical profession to be admitted to a hospital or other licensed health care facility; had surgery or had surgery recommended by a medical professional; or been advised by a medical professional to have any diagnostic test that was not completed *(excluding an AIDS-related test)*? ☐ Yes ☐ No

No coverage starts:

- Until the later of **1)** the date the Proposed Insured completed and signed the Application and paid the first full modal premium *(a check is not payment unless honored by the issuing institution when first presented)*; or **2)** the date the Proposed Insured completed all medical tests required by Assurity **and**
- Unless the Proposed Insured is insurable on the date coverage starts at Assurity's **standard or better than average rates** *(no ratings included)*, according to its underwriting practices for the amount of insurance and any additional benefits applied for.

If Proposed Insured dies while coverage under this Agreement is in effect, Assurity will pay the death benefit payable if the Policy applied for would have been issued at standard rates. However, Assurity shall not be liable for payment of any benefit over the amount of $500,000 *($250,000 for ages 70 through 75)*. Coverage under this Agreement is subject to the same terms, including any limitations or exclusions, which would be part of the Policy if issued as applied for.

If no Policy is issued and delivered and no benefit is paid under this Agreement, all premiums paid will be returned. If the Policy is issued as applied for, or if a Policy amendment is accepted by the Proposed Owner, premium paid will be applied to that Policy. No change in health will be used to deny a Policy if the change occurs after the later of: **1)** the date of the Application; or **2)** completion of all medical tests required by Assurity.

Coverage under this Agreement terminates automatically on the earliest of the date:

- 90 days from the date of the Application;
- Premium is returned by Assurity *(return is effective on being postmarked, properly addressed and postage prepaid)*;
- Coverage starts under any Policy resulting from the Application; or
- A Policy resulting from the Application is refused by the Proposed Owner.

The undersigned states that the answers on this Agreement and the Application are true and complete to the best of his/her knowledge and belief, and understands that the answers are relied upon for coverage under this Agreement. Assurity's liability will be limited to a return of the premium submitted if: **1)** the Proposed Insured dies by suicide; or **2)** the Application or this Agreement contains a material misrepresentation to Assurity.

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (888) 255-2060

TOBACCO USE QUESTIONNAIRE

Insured's Name _____ Policy No. _____
First *Middle* *Last*

During the past 12 months, have you smoked cigarettes? ..... ☐ Yes ☐ No

During the past 12 months, have you used any form of tobacco, nicotine-based products or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type(s) _____

If you have quit smoking or quit using tobacco in any form, please provide the date you quit ____/____/____ *(MM/DD/YYYY)*

I have read the above questions and declare that the answers are complete and true to the best of my knowledge and belief.

____/____/____ _____
Date (MM/DD/YYYY) *Signature of Insured*

SERFF Tracking Number:	*SEFL-126646674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46330*
Company Tracking Number:	*IND APP 2010-LIFE*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*IND APPS 2010-Life*		
Project Name/Number:	*IND APPS 2010-Life/IND APPS 2010-Life*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

READ CERT-L.pdf

READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word XP program and achieved the following test results:

Company Name: Assurity Life Insurance Company

Form Number(s):

Type of Form: Life Application

Form No.	Description	Flesch Score
47-350-05051 (R05-10)	Application for Insurance	55.6
47-351-05051 (R05-10)	Trust Information/Additional Beneficiary	64.4
47-352-05051 (R05-10)	General Section	50.0
47-354-05051 (R05-10)	Physician Information and Agreement	50.3
47-355-05051 (R05-10)	Life Product Section	53.0
47-357-05051 (R05-10)	Universal Life Product Section	54.0
47-362-05051 (R05-10)	Field Underwriter's Statement	57.3
75-802-02255	Temporary Conditional Insurance Agreement	50.8
75-819-05055	Tobacco Use Questionnaire	65.9

Carol S Watson
Signature

July 27, 2010
Date

Carol S. Watson
Vice President, General Counsel and Secretary